

TRINITY HEALTH AGE 19 AND OVER VERIFICATION FORM

If you have one or more dependent children age 19 and over who are eligible for continued coverage, you must complete this Age 19 and Over Verification Form. Be sure to sign the form and return it to your OTE/Human Resources Representative.

I, _____, hereby attest that each of my dependent children age 19 and over meet all of the following conditions:

1. They are unmarried;
2. They are the natural, legally adopted or court appointed dependent child of either me and/or my legal spouse. Legal spouses are those whom the IRS recognizes as a legal spouse. Common-law marriage is excluded;
3. They are not otherwise covered under any Trinity Health plan;

AND

Meet the definition of "Qualifying Child," provided they meet all of the following criteria:

1. They are under age 24 at the end of the calendar year;
2. They are enrolled as full-time students for at least five months of the year; and
3. They either:
 - have the same principal place of abode as I for more than half of the taxable year, and they do not provide more than half of their own support for the taxable year (also a "qualifying child"); or
 - have gross income for the taxable year, which is less than the exemption amount under Code Section 151(d) (\$3,650 for 2009), I provide over half of their support, and they are not anyone else's qualifying child.

OR

Meet the definition of a "Qualifying Relative," provided they meet all of the following criteria:

1. They are under age 26 at the beginning of the calendar year;
2. They have gross income for the taxable year which is less than the exemption amount under Code Section 151(d) (\$3,650 for 2009);
3. I provide over half of their support for the taxable year; and
4. They are not anyone else's qualifying child.

Following are all of the eligible dependent children age 19 and over for whom I am providing proof of dependent verification:

Dependent Child 1	Dependent Child 1 – please indicate the form(s) of documentation that are being provided as verification. Child's Name: _____ Date of Birth: ____ / ____ / ____ SSN: _____ <input type="checkbox"/> Federal Form 1040 that identifies child as a dependent (age 24 and under), or Either: <input type="checkbox"/> Proof of full-time student status (age 24 and under), or <input type="checkbox"/> Other proof of income not exceeding the exemption amount under code Section 151(d) (\$3,650 for 2009) (age 26 and under). If unable to provide proof, you may submit a notarized Health Care Affidavit form. <input type="checkbox"/> _____
Dependent Child 2	Dependent Child 2 – please indicate the form(s) of documentation that are being provided as verification. Child's Name: _____ Date of Birth: ____ / ____ / ____ SSN: _____ <input type="checkbox"/> Federal Form 1040 that identifies child as a dependent (age 24 and under), or Either: <input type="checkbox"/> Proof of full-time student status (age 24 and under), or <input type="checkbox"/> Other proof of income not exceeding the exemption amount under code Section 151(d) (\$3,650 for 2009) (age 26 and under). If unable to provide proof, you may submit a notarized Health Care Affidavit form. <input type="checkbox"/> _____

I agree that in the event that any of the above information changes, I will immediately notify my OTE/Human Resources Representative. I understand that if I misrepresent any facts on this form, I will be subject to coverage cancellation and disciplinary action, up to and including termination of employment, in accordance with my employer's policy.

Associate's Signature: _____ Date: _____